DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G448	A. BUILDING 00 B. WING	09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COMMUNITY RESOURCES INC	1325 BRENTWOOD COURT SOUTH BEND, IN46628

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W0000	This visit was for an annual fundamental recertification and state licensure survey. Dates of Survey: September 19, 20, 21 and 23, 2011 Facility number: 000962 Provider number: 15G448 AIM number: 100249360 Surveyor: Christine Colon, Medical Surveyor III/QMRP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/7/11 by Ruth Shackelford, Medical Surveyor III.	W0000		
W0104	The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the governing body failed for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) living at the group home, to exercise general operating direction in a manner to ensure routine maintenance was completed. Findings include: A morning observation was conducted on	W0104	The curtain rods for the windows in the living room, dining room and office have all been replaced and have the appropriate curtains on them to maintain privacy. The two rough plaster patches in the living room have been sanded and will be painted and the stained ceiling tiles in the dining room have been replaced. The agency governing body makes every effort to keep each facility in good repair. The plaster project	10/24/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	9/20/11 from 6:15 A.M. until 8:10 A.M.. Upon entering clients #1, #2, #3, #4, #5 and #6's home, the curtain rods over both windows in the living room were observed to be bent. There were 2 patches of rough plaster observed on the living room wall measuring 12 inches by 12 inches. The dining room window curtain rod was observed to be bent. Six ceiling tiles were observed to have brown stains. At 8:00 A.M., the window in the medication room was observed to have a beige sheet hanging from a vertical blind valance. Training Assistant (TA) #2 was observed to take down the sheet and the curtain rod was observed to be missing and the brackets on both sides of the window were observed to be broken. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/20/11 at 10:50 A.M.. The QMRP indicated there were repairs that needed to be completed but she wasn't sure if there were any maintenance repair request forms for this group home and she would have to check. No further documentation was available for review to indicate when the window fixtures and ceiling tiles would be repaired/replaced. 9-3-1(a)		had been started but not finished. In the future, if a repair project is started, but not finished in the designated time frame, a maintenance request will be submitted electronically as a well as verbal follow up to ensure a project that is started is finished. In the future, projects such as providing and replacing bent curtain rods and providing appropriate window covers/treatments will be completed by the Program Coordinator of the home if maintenance is unable to prioritize in a timely manner. If ceiling tiles become stained, a electronic maintenance request will be submitted with verbal follow up until repaired. Program Coordinator and Director of Group Living will make routine and sporadic checks to ensure the home is in good repair and to submit maintenance requests, as needed. Persons Responsible: Program Coordinator Director of Group Living	

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W0130	The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview, the facility failed for 1 of 3 clients observed during medication administration (client #5) to ensure privacy during medication administration. Findings include: An evening observation was conducted at the group home on 9/19/11 from 4:30 P.M. until 6:30 P.M.. At 5:00 P.M., clients #1, #2, #3, #5 and #6 were observed sitting at the dining table preparing to eat dinner. At 5:05 P.M., Training Assistant (TA) #1 was observed asking client #5 what his supper medication was and what the medication was for while clients #1, #2, #3 and #6 were seated at the dining tables and were able to hear medication information. Client #5 stated "Calcium for bones." There was no training regarding privacy observed during medication administration training. An interview with the Nurse was	W0130	An in-service training for house staff was completed on September 21 and October 11, 2011. The in-service included training on the importance of privacy when passing medication. Medications to be administered at mealtimes require the same degree of privacy. Staff are to refrain from administering medications in open areas such as the dining room. In the future, the Program Coordinator and the QMRP will do random observations of medication passes to ensure that the privacy of the individuals is being maintained. Persons Responsible:Program Coordinator QMRP	10/24/2011

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	conducted at the facility's administrative office on 9/20/11 at 1:00 P.M.. The Nurse indicated all clients should have privacy during medication administration training. 9-3-2(a)			
W0149	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility neglected to implement its "Policy for Handling Cases of Neglect and Abuse," to protect 2 of 6 clients living at the group home (clients #3 and #5) from physical aggression. Findings include: A review of the facility's records was conducted on 9/19/11 at 2:30 P.M.. Review of the facility's incident reports dated 1/1/11 to 9/19/11 indicated the following: Incidents involving client #5: 1. Incident report dated 1/29/11: "[Client	W0149	Please note that in example #2-client #6 was not involved in this incident. The discharged client was involved in the incident. **Client #1**has program strategies in place to role play confrontational scenarios with the staff daily during goal time. These scenarios are based on incidents that have occurred with client #1 and other individuals or within the household and client #1 gives examples of appropriate ways to handle the situation given. Scenarios to problem solving started out with general daily scenarios for Client #1 in which he needed to express and role play appropriate problem-solving and safe behavior. A new scenario was added to his strategies to address the specific incidents that occurred on 1/29/11, 4/1/11 and	10/31/2011

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	#5] came down from his room to get his morning medication. He was sitting in the med room when the staff excused themselves to go to the restroom and wash their hands. As staff was drying her hands and coming out of the bathroom she heard [client #5] say 'Ouch you hit me.' Upon entering the med room, the staff found [client #1] standing in the med room next to the desk and [client #5] standing holding the right side of his face between his lip and his jaw." 2. Incident dated 2/8/11: "[Client #6] and [client #5] had just returned home with the rest of their housemates from a community activity. [Client #5] was sitting in van seat directly behind the driver and [client #6] was sitting directly behind [client #5]. The staff heard [client #6] say that [client #5] told him to shut up and then [client #6] proceeded to hit [client #5] in the arm with an open hand. Both gentlemen proceeded to get off the van and went into the house." 3. Incident dated 4/17/11: "Was asking [client #3] to pick out one movie to watch. [Client #3] wasn't listening so I told him if he didn't want to listen he would go up to his room. He then grabbed a few movies in which case, I disconnected the t.v., I didn't want him messing with the t.v. to the point he		7/2/11 as each incident involved a different person, different issue, or different location. Client #1 has a behavior support plan that addresses physical aggression and has continued to have regular follow along with the psychiatrist to discuss behavioral issues. **<u>For the discharged client listed</u>**, initially he did not display any behavioral difficulties after moving into the group home. It was almost six months after moving in that he began to experience difficulties. At that time the agency began to work with the psychiatrist to adjust his medications to help with the aggression. Along with the change of medications, his behavior support plan was revised and implemented. As the problems progressed, the agency secured an outside behavior specialist to assist the QMRP and group home staff. The agency was also working to secure a new psychiatrist at the request of the individual's parents. The following is a timeline of the discharged client's time at the group home as well as list of steps taken to address his increased physical aggression as well as to maintain the safety of everyone involved. 6/11/10-client moved into group7/22/10-first behavior plan was approved and implemented. Staff trained to implement.8/23/10-began seeing psychiatrist-no initial problems and no changes	

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	would break another t.v.. I then picked up a movie from the floor, which [client #3] grabbed out of my hands, which upset [client #5]. [Client #5] started to walk towards [client #3]. I told [client #5] I could handle the situation and he needed to step away. As [client #3] was walking backwards away from me he bumped into [client #5], turned around and smacked [client #5] in the chest." 4. Incident dated 6/5/11: "[Client #5] moved towards the office inquiring something from another...I saw [discharged client name] follow him fast from the dinning (sic) room and behind him, he [discharged client name] hit [client #5] by his fist, and [client #5] shouted for help." . 5. Incident dated 6/7/11: "Went on transport, as the clients were getting into the van, [discharged client] told me we should go by his girlfriends van. I told him as we go by we can wave. [Client #5] was offended by [discharged client] trying to tell me what to do, and told [discharged client] to not do that. [Discharged client] immediately started to hit his head, told [client #5] and [discharged client] to calm down and not talk to each other and I would handle it. As soon as they calmed down, I got into the driver's seat and as I was putting my		made10/2010-appt with psychiatrist no difficulties and no changes made12/2010-appt with psychiatrist, client beginning to have difficulties with impulsiveness, re-direction and increased aggression towards others. Risperdal added. Behavior Support Plan evaluated and determined to be effective. Staff trained to implement consistently.1/2011-appt with psychiatrist, continued problems with aggression towards others, Depakote added. QMRP in process of establishing new baseline for physical aggression in order to effectively revise Behavior Support Plan.2/2011-appt with psychiatrist, some improvement with addition of Depakote. Easier to re-direct, no changes.3/2011-appt with psychiatrist, increase in difficulties with aggression again, increase Depakote. Behavior support plan revised and implemented. Staff trained to implement plan.4/2011-appt with psychiatrist, parents attended. Significant increase in behaviors, parents did not feel medication was helpful, psychiatrist discontinued all but original Celexa he was on when entered group home.5/2011-appt with psychiatrist, some improvement noted for a short time. IDT met with parents to identify additional options to assist in supporting the client to be successful. This included	

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	seatbelt on I heard [client #5] 'He hit me.' I turned around and asked [client #1] and [client #2] if they saw [discharged resident] hitting [client #5] they both nodded yes." Incidents involving client #3: 1. Incident report dated 3/27/11: "On 3/27/11 [discharged client] returned to the group home after a visit with his family. The staff report that they were working with [discharged client] to pack his lunch for work the next day when the phone rang and [client #3] answered it. When the staff got the phone from [client #3], it is reported that [discharged client] rushed over to [client #3] and hit and kicked him." 2. Incident dated 4/1/1: "The guys were walking in from transport. [Client #3] was in front of [discharged client] headed into the house. I stepped up to walk in between them (since we are trying to keep them away from each other). [Discharged client] told [client #3] 'You're not going anywhere tonight.' [Client #3] said that he was going somewhere. [Discharged client] reached around me and pinched [client #3] on his arm (upper right) and then swung his leg around and kicked the side of [client #3]'s left leg."		using visual calendar planning of preferred activities, was connected to a male staff advocate of his choice for problem-solving, and new activities were identified for him that he was responsive to that included house photographer. Parents request a new psychiatrist.6/7/2011-meeting with parents, searching for a new psychiatrist as well as a behavior specialist to assist QMRP and staff with programming.6/8/2011-client's parents decided to take home while they decided on the appropriateness of his placement. QMRP continued to work on securing a new psychiatrist and behavior specialist. A behavior specialist was secured and planning to visit but on 6/21/11 parents decided to take individual out of program and have him return to their home. **For client #3** Per the incident report, further information regarding the incident that occurred on 4/17/11, the physical aggression that occurred was determined to be more of a fear trigger response to him backing into client #5 and that there was no intent to cause harm. Client #3 does have a behavior support plan in place that does address physical aggression and the staff document on this plan daily. For client #3 there are also other strategies to assist with his behavioral issues. These include separate transportation times in	

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	3. Incident dated 4/1/11: "...[Client #3] was sitting with me in the office as I filled out a form. He went out to grab his markers to do his letters. [Client #1] came into the office while he was gone and was hovering. When [client #3] came back in [client #1] yelled at him to get out. I told [client #1] it was okay and that I had asked [client #3] to be in the office. I turned back to what I was doing at the desk and looked up to see [client #1] dart across the room and slap [client #3] across the face (above his right eye)." . 4. Incident dated 4/19/11: "[Client #3] had just been involved in another incident which [discharged client] had witnessed and [client #3] was headed into the kitchen from the garage to get his coat on. I was pulling the van into the garage and saw that [discharged client] had pinned [client #3] against the glass door and pinched [client #3] on the arm. [Client #3] yelled in pain.'" 5. Incident dated 6/8/11: "On 6/8/11 at 6:45 A.M., the staff heard noises and screaming coming from upstairs. The staff went upstairs and found [discharged client] holding [Client #3] against the wall by the neck and hitting him in the head." 6. Incident dated 7/2/11: "[Client #3] was standing in the kitchen near the office		the afternoon to give him some quiet time to relax after returning home as well as more individualized activities such as shopping. There are also seating arrangements for mealtimes and when riding in the van to help decrease incidents of aggression. These individualized strategies address transition times in effort to provide structure, routine, and stability which then leads to less behavioral issues. In the future, every effort will be made to prevent abuse, neglect and mistreatment to clients. If client to client aggression occurs, each incident will be reported. Within 24 hours, after each incident, the circumstances that led up to the incident will be assessed and evaluated in order to identify what triggered the inappropriate behavior in order to prevent further incidents. The QMRP will review, evaluate, and implement recommendations to prevent future incidents. Recommendations will include formal and/or informal individualized strategies/techniques to address and teach appropriate adult behavior in effort to prevent future occurrences. Based on the outcome of the evaluation, it will determine what steps need to be put into place. For example, if an incident occurs in the van during transport, a seating chart may need to be established, or different transportation times be	

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	entry. [Client #1] approached [client #3], yelling at him. [Client #1] suddenly hit [client #3] in the back of the head with a closed fist. [Client #3] fell to the floor. [Client #3] was dazed, complaining of dizziness and pain in the head and neck." A review of the facility's policy titled, "Policy: P-22-03 - Abuse, Neglect, or Exploitation" dated 10/6/08, was conducted on 9/19/11 at 2:55 P.M. and indicated, "...prohibits the abuse, neglect, exploitation, mistreatment or the violation of the rights of any individual receiving services...Definitions: Abuse/Mistreatment: Abuse can be verbal, physical, sexual and mental...Physical abuse involves willful infliction of injury, unnecessary physical or chemical restraints or isolation, and punishment with resulting physical harm or pain...Neglect/Mistreatment: Failure to provide appropriate care, food, medical care or supervision." An interview with the Qualified Mental Retardation Professional (QMRP) was conducted at the facility's administrative office on 9/20/11 at 10:45 A.M.. The QMRP indicated clients #1, #3, #5 and #6 were involved in the incidents of physical aggression. The QMRP further indicated the facility's abuse/neglect policy should be followed at all times.		established. Staff will receive training, as appropriate, to implement recommended techniques/strategies. The Director of Group Living will review each incident and evaluate the recommendations implement in effort to ensure timeliness, effectiveness, and prevention. Persons RESPONSIBLE:QMRPDirector of Group Living Additional information requested and provided 10/27/2011As is indicated in our policy, while we are assessing and evaluating incidents of aggression between residents every effort will be made to protect other residents. This might include such things as removing the other residents from the situation, removing the residents involved from the situation, increase staffing to provide supervision, identifying alternate modes of transportation for the residents, altering resident schedules, modifying behavior support plans, etc. The strategy utilized to protect the residents may vary dependent on the situation. Staff will be retrained on the need to protect other residents while incidents are being investigated and measures to address behaviors being developed to the point of implenmentation.	

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W0157	If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed for 4 of 6 clients residing at the group home (clients #1, #3, #5 and #6) to take effective corrective action for 11 of 11 reported incidents of client to client aggression. Findings include: A review of the facility's records was conducted on 9/19/11 at 2:30 P.M.. Review of the facility's incident reports dated 1/1/11 to 9/19/11 indicated the following: Incidents involving client #5: 1. Incident report dated 1/29/11: "[Client #5] came down from his room to get his morning medication. He was sitting in the med room when the staff excused themselves to go to the restroom and wash their hands. As staff was drying her hands and coming out of the bathroom she	W0157	Please note that in example #2-client #6 was not involved in this incident. The discharged client was involved in the incident. **Client #1** has program strategies in place to role play confrontational scenarios with the staff daily during goal time. These scenarios are based on incidents that have occurred with client #1 and other individuals or within the household and client #1 gives examples of appropriate ways to handle the situation given. Scenarios to problem solving started out with general daily scenarios for Client #1 in which he needed to express and role play appropriate problem-solving and safe behavior. A new scenario was added to his strategies to address the specific incidents that occurred on 1/29/11, 4/1/11 and 7/2/11 as each incident involved a different person, different issue, or different location. Client #1 has a behavior support plan that addresses physical aggression and has continued to have regular follow along with the psychiatrist to discuss behavioral	10/31/2011

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	heard [client #5] say 'Ouch you hit me.' Upon entering the med room, the staff found [client #1] standing in the med room next to the desk and [client #5] standing holding the right side of his face between his lip and his jaw." No documentation was available for review to indicate the facility took effective corrective action after this incident. 2. Incident dated 2/8/11: "[Client #6] and [client #5] had just returned home with the rest of their housemates from a community activity. [Client #5] was sitting in van seat directly behind the driver and [client #6] was sitting directly behind [client #5]. The staff heard [client #6] say that [client #5] told him to shut up and then [client #6] proceeded to hit [client #5] in the arm with an open hand. Both gentlemen proceeded to get off the van and went into the house." No documentation was available for review to indicate the facility took effective corrective action after this incident. 3. Incident dated 4/17/11: "Was asking [client #3] to pick out one movie to watch. [Client #3] wasn't listening so I told him if he didn't want to listen he would go up to his room. He then grabbed a few movies in which case, I disconnected the t.v., I didn't want him messing with the t.v. to the point he		issues. **For the discharged client listed**, initially he did not display any behavioral difficulties after moving into the group home. It was almost six months after moving in that he began to experience difficulties. At that time the agency began to work with the psychiatrist to adjust his medications to help with the aggression. Along with the change of medications, his behavior support plan was revised and implemented. As the problems progressed, the agency secured an outside behavior specialist to assist the QMRP and group home staff. The agency was also working to secure a new psychiatrist at the request of the individual's parents. The following is a timeline of the discharged client's time at the group home as well as list of steps taken to address his increased physical aggression as well as to maintain the safety of everyone involved. 6/11/10-client moved into group7/22/10-first behavior plan was approved and implemented. Staff trained to implement.8/23/10-began seeing psychiatrist-no initial problems and no changes made10/2010-appt with psychiatrist no difficulties and no changes made12/2010-appt with psychiatrist, client beginning to have difficulties with impulsiveness, re-direction and increased aggression towards others. Risperdal added.	

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	would break another t.v.. I then picked up a movie from the floor, which [client #3] grabbed out of my hands, which upset [client #5]. [Client #5] started to walk towards [client #3]. I told [client #5] I could handle the situation and he needed to step away. As [client #3] was walking backwards away from me he bumped into [client #5], turned around and smacked [client #5] in the chest." No documentation was available for review to indicate the facility took effective corrective action after this incident. 4. Incident dated 6/5/11: "[Client #5] moved towards the office inquiring something from another...I saw [discharged client name] follow him fast from the dinning (sic) room and behind him, he [discharged client name] hit [client #5] by his fist, and [client #5] shouted for help." No documentation was available for review to indicate the facility took effective corrective action after this incident. 5. Incident dated 6/7/11: "Went on transport, as the clients were getting into the van, [discharged client] told me we should go by his girlfriends van. I told him as we go by we can wave. [Client #5] was offended by [discharged client] trying to tell me what to do, and told [discharged client] to not do that.		Behavior Support Plan evaluated and determined to be effective. Staff trained to implement consistently.1/2011-appt with psychiatrist, continued problems with aggression towards others, Depakote added. QMRP in process of establishing new baseline for physical aggression in order to effectively revise Behavior Support Plan.2/2011-appt with psychiatrist, some improvement with addition of Depakote. Easier to re-direct, no changes.3/2011-appt with psychiatrist, increase in difficulties with aggression again, increase Depakote. Behavior support plan revised and implemented. Staff trained to implement plan.4/2011-appt with psychiatrist, parents attended. Significant increase in behaviors, parents did not feel medication was helpful, psychiatrist discontinued all but original Celexa he was on when entered group home.5/2011-appt with psychiatrist, some improvement noted for a short time. IDT met with parents to identify additional options to assist in supporting the client to be successful. This included using visual calendar planning of preferred activities, was connected to a male staff advocate of his choice for problem-solving, and new activities were identified for him that he was responsive to that included house photographer.	

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	[Discharged client] immediately started to hit his head, told [client #5] and [discharged client] to calm down and not talk to each other and I would handle it. As soon as they calmed down, I got into the driver's seat and as I was putting my seatbelt on I heard [client #5] 'He hit me.' I turned around and asked [client #1] and [client #2] if they saw [discharged resident] hitting [client #5] they both nodded yes." No documentation was available for review to indicate the facility took effective corrective action after this incident. Incidents involving client #3: 1. Incident report dated 3/27/11: "On 3/27/11 [discharged client] returned to the group home after a visit with his family. The staff report that they were working with [discharged client] to pack his lunch for work the next day when the phone rang and [client #3] answered it. When the staff got the phone from [client #3], it is reported that [discharged client] rushed over to [client #3] and hit and kicked him." No documentation was available for review to indicate the facility took effective corrective action after this incident. 2. Incident dated 4/1/1: "The guys were walking in from transport. [Client #3]		Parents request a new psychiatrist.6/7/2011-meeting with parents, searching for a new psychiatrist as well as a behavior specialist to assist QMRP and staff with programming.6/8/2011-client's parents decided to take home while they decided on the appropriateness of his placement. QMRP continued to work on securing a new psychiatrist and behavior specialist. A behavior specialist was secured and planning to visit but on 6/21/11 parents decided to take individual out of program and have him return to their home. **For client #3** Per the incident report, further information regarding the incident that occurred on 4/17/11, the physical aggression that occurred was determined to be more of a fear trigger response to him backing into client #5 and that there was no intent to cause harm. Client #3 does have a behavior support plan in place that does address physical aggression and the staff document on this plan daily. For client #3 there are also other strategies to assist with his behavioral issues. These include separate transportation times in the afternoon to give him some quiet time to relax after returning home as well as more individualized activities such as shopping. There are also seating arrangements for mealtimes and when riding in the van to help decrease incidents of aggression.	

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	was in front of [discharged client] headed into the house. I stepped up to walk in between them (since we are trying to keep them away from each other). [Discharged client] told [client #3] 'You're not going anywhere tonight.' [Client #3] said that he was going somewhere. [Discharged client] reached around me and pinched [client #3] on his arm (upper right) and then swung his leg around and kicked the side of [client #3]'s left leg." No documentation was available for review to indicate the facility took effective corrective action after this incident. 3. Incident dated 4/1/11: "...[Client #3] was sitting with me in the office as I filled out a form. He went out to grab his markers to do his letters. [Client #1] came into the office while he was gone and was hovering. When [client #3] came back in [client #1] yelled at him to get out. I told [client #1] it was okay and that I had asked [client #3] to be in the office. I turned back to what I was doing at the desk and looked up to see [client #1] dart across the room and slap [client #3] across the face (above his right eye)." No documentation was available for review to indicate the facility took effective corrective action after this incident. 4. Incident dated 4/19/11: "[Client #3] had just been involved in another incident		These individualized strategies address transition times in effort to provide structure, routine, and stability which then leads to less behavioral issues. Each incident listed has at a minimum an agency incident report. State reportable incidents were filed for incidents when required per DDRS policy BQIS 460 0301 008. Each internal incident is reviewed by the QMRP and the Director of Group Living and investigation notes/comments with follow-up are made regarding the investigation into the incident as well as actions to be taken. In some instances there is also information regarding meetings that were held to address the issue as well as new strategies that will be implemented. Some reports also have information from the nurse that may have evaluated someone that was the target of an aggressive act. Therefore, there was documentation available for review that would indicate corrective actions were taken in effort to prevent further incidents. In the future, every effort will be made to prevent abuse, neglect and mistreatment to clients. If client to client aggression occurs, each incident will be reported. Within 24 hours, after each incident, the circumstances that led up to the incident will be assessed and evaluated in order to identify what triggered the inappropriate	

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	which [discharged client] had witnessed and [client #3] was headed into the kitchen from the garage to get his coat on. I was pulling the van into the garage and saw that [discharged client] had pinned [client #3] against the glass door and pinched [client #3] on the arm. [Client #3] yelled in pain.'" No documentation was available for review to indicate the facility took effective corrective action after this incident. 5. Incident dated 6/8/11: "On 6/8/11 at 6:45 A.M., the staff heard noises and screaming coming from upstairs. The staff went upstairs and found [discharged client] holding [Client #3] against the wall by the neck and hitting him in the head." No documentation was available for review to indicate the facility took immediate effective corrective action after this incident. 6. Incident dated 7/2/11: "[Client #3] was standing in the kitchen near the office entry. [Client #1] approached [client #3], yelling at him. [Client #1] suddenly hit [client #3] in the back of the head with a closed fist. [Client #3] fell to the floor. [Client #3] was dazed, complaining of dizziness and pain in the head and neck." No documentation was available for review to indicate the facility took effective corrective action after this		behavior in order to prevent further incidents. The QMRP will review, evaluate, and implement recommendations to prevent future incidents. Recommendations will include formal and/or informal individualized strategies/techniques to address and teach appropriate adult behavior in effort to prevent future occurrences. Based on the outcome of the evaluation, it will determine what steps need to be put into place. For example, staffing patterns or staffing ratios may need to be adjusted. Staff will receive training, as appropriate, to implement recommended techniques/strategies. The Director of Group Living will review each incident; evaluate the recommendations implemented and documentation in effort to ensure timeliness, effectiveness, and prevention. Persons RESPONSIBLE:QMRPDirector of Group LivingAdditional information as requested provided 10/27/2011As is indicated in our policy, while we are assessing and evaluating incident s of aggression between residents every effort will be made to protect other residents. This might include such things as removing the other residents from the situation, removing the residents involved from the situation, increase staffing to provide supervision, identifying	

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	incident. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/20/11 at 10:45 A.M.. The QMRP indicated there was no documentation available for review to indicate the facility took effective corrective action to address each of these incidents involving clients #1, #3, #5 and #6. 9-3-2(a)		alternate modes of transportation for the residents, altering resident schedules, modifying behavior support plans, etc. The strategy utilized to protect the residents may vary dependent on the situation. Staff will be retrained on the need to protect other residents while incident s are being investigated and measures to address behaviors being developed to the point of implementation.	
W0261	The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. Based on record review and interview, the facility failed to have needed members serve on the Human Rights Committee for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) residing at the group home.	W0261	LOGAN's Human Rights Committee met on 10/10/11 and discussed the membership of a person with a disability. A specific name was discussed. An offer was extended to this individual. The individual accepted the offer and confirmed	10/24/2011

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	Findings include: A review of the facility's records was conducted at the facility's administrative office on 9/20/11 at 11:32 A.M.. A review of the facility's "Human Rights Committee Meeting Minutes" indicated the following: Meeting Date: 2/14/11: Review of the 2/14/11 minutes indicated no client representative in attendance. Meeting Date: 3/14/11: Review of the 3/14/11 minutes indicated no client representative in attendance. Meeting Date: 4/11/11: Review of the 4/11/11 minutes indicated no client representative in attendance. Meeting Date: 5/9/11: Review of the 5/9/11 minutes indicated no client representative in attendance. Meeting Date: 6/13/11: Review of the 6/13/11 minutes indicated no client representative in attendance. Meeting Date: 7/11/11: Review of the 7/11/11 minutes indicated no client representative in attendance. Meeting Date: 8/8/11: Review of the		that she was willing to serve on the committee. She will be in attendance at the meeting of 11/14/11 which is the next and earliest HRC meeting. LOGAN's Human Right Committee will retain on its membership roster the members required by policy. As individual members leave the HRC, they will be replaced with a similar member with the same membership credentials in a timely manner. Person(s) Responsible: VP for Program Operations	

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	8/8/11 minutes indicated no client representative in attendance. Meeting Date: 9/12/11: Review of the 9/12/11 minutes indicated no client representative in attendance. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/20/11 at 3:55 P.M.. When asked if the facility's HRC had a client representative, the QMRP indicated the facility did have clients that were capable of serving as a client representative and were in the process of interviewing clients to serve as a client representative on the facility's HRC. 9-3-4(a)			
W0336	Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility failed for 3 of 3 sampled clients (client #1, #2 and #3) with medical conditions, to have quarterly nursing assessments completed in a timely	W0336	Nursing assessments were completed for all clients at Brentwood on Sept 28 th , 2011. In keeping with the quarterly schedule they will be completed again at the designated quarter in November 2011.	10/24/2011

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	fashion. Findings include: Client #1's records were reviewed on 9/20/11 at 12:00 P.M.. The record review failed to indicate the quarterly nursing assessments had been completed timely. Client #1's quarterly nursing assessments were dated 11/24/10, 2/24/11 and 5/24/11. Further review of client #1's record indicated he was not in need of a medical care plan and an annual physical dated 4/1/11. No further documentation was available for review to indicate client #1 had a nursing quarterly completed for the month of 8/11. Client #2's records were reviewed on 9/20/11 at 12:30 P.M.. The record review failed to indicate the quarterly nursing assessments had been completed timely. Client #2's quarterly nursing assessments were dated 2/24/11 and 5/24/11. Further review of client #2's record indicated he was not in need of a medical care plan and an annual physical dated 1/12/11. No further documentation was available for review to indicate client #2 had a nursing quarterly completed for the month of 8/11. Client #3's records were reviewed on		With the hiring of a new nurse designated for the Brentwood home, future quarterly nursing assessments will be completed in a timely manner each quarter or more often if needed. Person Responsible: Group Living Nurse	

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	9/20/11 at 11:35 A.M.. The record review failed to indicate the quarterly nursing assessments had been completed timely. Client #3's quarterly nursing assessments were dated 11/24/10, 2/24/11 and 5/24/11. Further review of client #3's record indicated he was not in need of a medical care plan and an annual physical dated 3/7/11. No further documentation was available for review to indicate client #3 had a nursing quarterly completed for the month of 8/11. The Nurse was interviewed on 9/20/11 at 1:00 P.M.. The Nurse indicated the nursing assessments were not completed quarterly. The Nurse further indicated no nursing quarterlies were completed for clients #1, #2 and #3 for the month of August 2011. 9-3-6(a)			